

Medical Record Management

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MEDICAL RECORD MANAGEMENT

Medical records shall be maintained in accordance with the following guidelines:

Content

1. The medical record shall contain sufficient information to identify and assess the patient and furnish evidence on the course of the patient's health/medical care.
2. The record shall include accurate and legible documentation of any local health department activity involving or affecting the patient's health to include but not be limited to assessment, tests, results, and treatment. Red or fluorescent allergy stickers may be displayed on the front of a medical record to alert the health care provider of a potential emergency that can interfere with a patient's medical care or treatment. Allergies may also be written in red within a medical record.
3. All medical records must be maintained in a standard format with entries and forms filed in chronological order with the most recent on top.
4. Each form/document filed within the record shall include the patient's name, identification number and clinic identifier. (The computer generated C or D label may be used.)
5. Each entry in the record shall contain the date of service, description of service, provider's signature and title.
NOTE: A service providers' legend must be maintained which contains the signature, title of provider, provider's initials and employee ID number. It is to be retained permanently and kept current of new certifications or license privileges. (See "Scope of Practice" in Administrative Reference (AR) Volume I, Personnel Section for instructions on updating license/certification of personnel.)
6. Documentation shall be done in accordance with the Public Health Practice Reference (PHPR) Documentation guidelines (See Documentation/Medical Record Section of the PHPR).

Filing And Maintenance Of Medical Records

1. Each patient receiving personal health services shall have a record initiated. (Exception: anonymous HIV test/counseling patient.)
2. The medical record shall be maintained in the health department (service delivery site) where services are delivered.
3. Medical records may be filed in alphabetical or numerical order.
4. A Master Patient Index shall be maintained permanently as a locator system for the records at each health center where the service was initiated/provided.
5. The Master Patient Index must be in alphabetical order by patient's last name.

6. The index shall include the complete patient name, patient identification number, date of birth, gender, race, file number (if numeric system is used), father's full name, mother's full maiden name or legal guardian (if such information is necessary for identification of the patient), and location of record—if it is not in the active file.
7. All documentation regarding the patient (including the CH-2 Immunization/Master Record with documentation) shall be filed in one record (unit record) with the exception of patients of the licensed home health agencies and if the local health department (LHD) elects to maintain Health Access Nurturing Development Services(HANDS) records separately.
8. HANDS records may be maintained separately but LHDs are encouraged to integrate these records with the unit record.
9. Documentation of immunizations must be made on the CH-2 (cardstock weight paper) Immunization Record/Master Record.
10. Records for recipients of mass flu immunization clinics when only an influenza administration record is initiated and maintained are not required to be part of the index. They should be filed by year in alphabetical order by patient's last name placed in a file drawer where they are secure and can be easily accessed.
11. Records for the KIDS Smile Program shall be kept as follows:
 - a. If a child does not have a complete medical record and receives the dental varnish in the health department, the personal record for KIDS Smile shall be retained by the LHD in a folder marked KIDS Smile, 2004-2005 in alphabetical order, by patient name. These forms should be kept for fiscal year and not calendar year. For offsite Fluoride Varnish screenings and applications (schools, etc.), place the personal record for KIDS Smile and any related forms in a folder with the date (i.e. KIDS Smile 2004-2005) and keep in alphabetical order by the name of preschool/school or offsite location where the fluoride varnish was applied. Do not file these forms/records for offsite Fluoride Varnish screenings and application with the Patient Encounter Form (PEF) forms.
 - b. When services are provided in the clinic, the personal record (screening, application of fluoride varnish, providing a preventive health message and referral to a dentist if necessary) shall be retained in the child's medical record if such a record exists.
12. When the medical record is pulled from the active file for serving the patient or when working with the record, an "out guide" is to be used in the place of the record. The "out guide" identifies the location of the record and stays in the file until the folder/chart is filed back.
13. Medical records are to be returned to the centralized record section upon completion of services and/or before the facility is closed on evenings, weekends, or holidays.
14. Medical records shall be filed in a secure location that is locked during non-clinic hours to safeguard against loss, tampering, or use by unauthorized personnel. Care shall be given to assure that the area containing medical records is secured during clinic hours from patient or visitor access and that records are sufficiently distant from patient or visitor accessible areas to prevent viewing names or medical information. (For guidelines, see "Privacy and Security of Protected Health, Confidential and Sensitive Information Guidelines" in AR Volume I, Personnel Section.)

15. Medical records shall be retained in accordance with the Local Health Department [Record Retention and Disposal Schedule](#). (See the current Records Retention and Disposal Schedule and guidelines for applying the Records Retention Schedule to the Medical Record in this section.)

Ownership of Records

1. The medical record is the property of the local health department. Records shall not be taken from the facility except by court order. This does not preclude the routing of copies of the patient's records or portions thereof, including X-ray film, to physicians for consultation; or in those instances where delivery of services calls for it e.g., Home Health.
2. When the LHD provides services off-site, such as in a private physician's office, clinic, or schools the documentation/record of these services is property of the LHD and shall be maintained separately/apart from the medical record of the contracted agency/physician(s).

Releasing Patient Information

1. All medical records shall be regarded as confidential.
2. Medical record information may be released only with the consent of the patient, parent or legal guardian of the patient, or as directed by law.
3. Immunization information may be shared, without authorization from the patient or the patient's parent or guardian, if the patient is a minor, if the person or agency requesting the information provides health related or education services on behalf of the patient or has a public health interest or is an institution which requires evidence of immunizations pursuant to state law. Some of those entities that may report and exchange information under this exemption are: LHDs within and outside the state, childcare facilities, pre-schools, public and private schools and other providers outside of the LHD who are providing health care to the patients simultaneously or subsequently. See Administrative Regulation [902 KAR 2:055](#) for a complete list of entities that may report and exchange immunization information.
4. Patient information regarding Sexually Transmitted Diseases (STD), the HANDS program, mental health and drug and alcohol abuse shall be considered privileged information and must be specifically authorized in the written release signed by the patient or legal guardian prior to the release of these records.
5. Policies and procedures regarding releases of information shall be established and a designated custodian and a designee appointed to handle day-to-day occurrences.
6. The policies regarding the release of medical records shall be posted (according to the "[Open Records](#)" law) in a conspicuous place for the public to see.
7. All matters relating to releasing information shall be referred to the designated custodian.
8. The policies shall address each type of information the custodian can release and the conditions under which the information shall be released.
9. In accordance with Kentucky Law, a patient who receives service from a local health department may have access to his/her medical record upon presentation of appropriate

identification; however, the same law allows the health department up to three working days to decide if the request is appropriate.

10. Medical records shall be made available, when requested, for inspection by duly authorized representatives of the Kentucky Cabinet for Health and Family Services. Any refusal to honor an authorization for the release of information shall be documented and the reason stated.
11. For further guidelines and procedures for releasing patient information, subpoenas and court orders, see Procedures for Release of Medical Record Information in this section.

Transferring The Medical Record Within County School Sites

1. The medical record may be transferred from one school site to another within the same county.
2. When the record is transferred, the sending school site shall note the date of transfer and the name of the school site to which the record is being transferred on the Master Patient Index.
3. The medical record being transferred shall be placed in a sealed envelope to ensure confidentiality and safety while en route to the receiving health delivery site.
4. Upon the student's leaving the school system, the record should be returned to the health department and integrated with the health department chart if one is available.
5. These records are to be retained in accordance with the current Records Retention Schedule.

"Health Insurance Portability and Accountability Act" (HIPAA) And The "Family Education Rights and Privacy Act" (FERPA)

Both HIPAA and FERPA provide equal protection. When schools handle information, they use FERPA. When health departments are in the school and providing information that will be put in the school files, the LHD acknowledges FERPA. However, the copy of information that is to be removed for health department filing is protected by HIPAA.

When a school provides health care to students in the normal course of business, such as through its health clinic, it is also a "health care provider" as defined by *HIPAA*. If a school also conducts any covered transactions electronically in connection with that health care, it is then a covered entity under *HIPAA*. As a covered entity, the school must comply with the *HIPAA* Administrative Simplification Rules for Transactions and Code Sets and Identifiers with respect to its transactions.

However, many schools, even those that are *HIPAA* covered entities, are not required to comply with the *HIPAA* Privacy Rule because the only health records **maintained by the school** are "education records" or "treatment records" of eligible students under FERPA, both of which are excluded from coverage under the *HIPAA* Privacy Rule. See the exception at paragraph (2)(i) and (2)(ii) to what is considered "protected health information" (PHI) at 45 *CFR* § 160.103. In addition, the exception for records covered by *FERPA* applies both to the *HIPAA* Privacy Rule,

as well as to the *HIPAA* Security Rule, because the Security Rule applies to a subset of information covered by the Privacy Rule (i.e., electronic PHI).

The term “education records” is broadly defined to mean those records that are: (1) directly related to a student, and (2) **maintained** by an educational agency or institution or by a party acting for the agency or institution. See 34 *CFR* § 99.3. “Treatment records” under *FERPA*, as they are commonly called, are records on a student who is eighteen years of age or older, or is attending an institution of postsecondary education,...

However, **maintaining the records** by the school according to *FERPA* **differs** from **a qualified medical professional actually providing the medical services and electronically billing those services**. As a covered entity, all services provided (delivered) by a qualified medical provider and electronically billed are subject to *HIPAA* Administrative Simplification rules compliance.

Information on the *HIPAA* Privacy Rule is available at: <http://www.hhs.gov/ocr/hipaa/>.

Information on the other *HIPAA* Administrative Simplification Rules is available at: <http://www.cms.hhs.gov/HIPAAGenInfo/>.

Information on **Joint Guidance on the Application of the *Family Educational Rights and Privacy Act (FERPA)* and the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* to Student Health Records**

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hipaaferpajointguide.pdf>

FORMS AND DOCUMENTATION

Local Health Departments (LHDs) are responsible for documentation of services and activities of their respective organization. Many of the programs within the Department for Public Health (DPH) furnish the required hard copy or electronic forms for documentation that collect information necessary to comply with their program's current laws, regulations or guidelines for documentation purposes. Other programs have electronically developed the format and/or have succinctly identified data elements to record to enable the LHDs to create and/or print their own for documentation purposes.

When the DPH has not mandated use of the printed form or electronic form, or the format and the LHD has elected to develop its own, the LHD has the responsibility for assuring the form is current and contains the specific data elements required to comply with the current applicable laws, regulations and guidelines.

Best medical record practice dictates that documentation should not be duplicated in the medical record. If a LHD elects to collect/record duplicate information that results in inconsistencies, the LHD will be liable for audit exceptions that could result in loss of federal and state funds.

The Public Health Practice Reference (PHPR) and this Administrative Reference (Volumes I and II) contain the current specific data collection and documentation requirements that comply with state and federal laws, regulations and guidelines.

CONSENT/AUTHORIZATION FOR SERVICES

A general consent is required for each person prior to clinical/personal health service provision. The general consent is obtained as part of the registration process. The signed consent is valid for one year from date signed. (See PSRS Section of AR Volume II for the Registration, Authorizations, Certifications and Consents Form.) A general consent statement will be reviewed and signed by the patient, parent, or legal guardian. This consent will cover all general medical services.

For WIC certification services only, a minor patient seeking WIC as pregnant, a parent, caretaker, guardian, or proxy may sign the general consent form and provide current health data or birth measures, income and diet information. Services that require more in-depth explanation (informed consent) will require an additional signature after the patient, parent or legal guardian has been given adequate information to make an informed decision about the service or treatment to be rendered. Guidelines for who may give consent are contained on the following pages.

When providing health services, it is essential that the health professional ensure to the extent possible that the patient, parent, or legal guardian fully understands the treatment being provided.

With any procedure or treatment of a patient, there are certain risks that are present. It is the duty of the medical professionals to be aware of the risks and inform the patient of the procedure to be performed, acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatments or procedures, which are recognized among other health care providers who perform similar treatments or procedures. (KRS 304.40-320)

Informed Consent **MUST** be completed and signature obtained by the medical staff person providing the service. This consent must be signed and dated by the patient/parent/legal guardian.

“Informed consent” comprises seven (7) basic elements. To help remember these elements, think of the word “**BRAIDED**”:

- **B**enefits of the drug, procedure, service.
- **R**isks of the drug, procedure, service.
- **A**lternatives to the drug, procedure, service.
- **I**nquiries about the drug, procedure, service are the patient’s, parent’s, legal guardian’s right and responsibility.
- **D**ecision to refuse the drug, procedure, and service without penalty is the patient’s, parent’s, or legal guardian’s right.*
- **E**xplanation of the drug, procedure, service is owed the patient, parent or legal guardian.
- **D**ocumentation that the health professional has covered each of the previous six points, usually by use of a consent form or statement.

Certain procedures or services require **specific consent forms** (See PHPR Family Planning Section):

- Federally required Consent for Sterilization (OMB 0937-0166)
- Consent for Norplant Removal (ACH-266)

- Consent for Insertion/Removal Intrauterine Device (IUD) (ACH-280)
- Consent for deferring a physical examination for three (3) months for Oral Contraceptives and Depo Provera (ACH-264B)
- Informed Consent for Vaccines (IMM-1)
- Informed Consent for Family Planning Method (FP-1)
- Informed Consent and Waiver of Liability for Administration of Depo Provera Contraceptive (FP-2)

*A patient's decision to refuse a procedure (such as hemoglobin or hematocrit) may cause the person to be ineligible for a service that requires the procedure to determine eligibility (see specific service guidelines).

Only The Patient Shall Give Consent Or Authorization For Services Unless One Of The Following Situations Exists:

1. The patient is a minor (under 18 years of age - according to KRS 2.015) and is living with her/his parent(s), legal guardian, or under the custody or control of the Cabinet for Health and Family Services. In these cases, either the parent, legal guardian, or a Cabinet for Health and Family Services social worker may legally give consent, as applicable.
2. Exceptions to parental or guardian consent for minors (patients under 18 years of age) to receive services are:
 - Patient is under 18 years of age, self-supporting and living apart from the parent's residence. The patient, even though a minor, may give consent, provided services are fully explained and she/he seems to understand any associated risk.
 - Patient is under 18 years of age and has contracted a lawful marriage (and therefore emancipated) and may give consent for services, provided associated risks are fully comprehensible to him/her (KRS 214.185).
 - Patient is under 18 years of age, unmarried and has borne or fathered a child. The patient may give consent for services for her/his child and herself/himself without the consent of the patient's parent or guardian (KRS 214.185).
 - Patient is under 18 years of age and seeks diagnosis and/or treatment for sexually transmitted disease, pregnancy, alcohol and/or drug abuse or addiction. The local health department may treat the minor for sexually transmitted disease, contraception, pregnancy or childbirth upon consent of the minor and without the consent or notification of the parent(s), guardian, or any other person having custody of the minor patient. Treatment shall not include inducing of an abortion or the performance of a sterilization operation (KRS 214.185).
 - Patient is a minor and victim of a sexual offense. He/she, even though a minor, may consent to examination by a physician and such consent is not subject to disaffirmance because of minority. Consent of his/her parent(s) or guardian is not required for such an examination. (KRS 216B.400).

3. The patient is 18 years of age or older that is mentally disabled. If a patient has been adjudged by a court to be mentally disabled, then the court appointed guardian has legal authority to give consent. (KRS 387.660)
4. A person may also be considered “disabled” if they are in the midst of a procedure and unconscious or otherwise incapable of giving informed consent. In such instances, consent for additional treatment may be given by next of kin.
5. Foster Parents should not sign consent for “medical services” performed at the local health department, however they may sign for Women, Infant, Children (WIC) services (see “Use of Proxies” in the AR, Volume I, WIC Section). For a child in foster care, LHDs should contact the local Department for Community Based Services (DCBS) Social Services Worker (SSW) or supervisor if a child needs medical services. The SSW or supervisor will determine the type of custody designation the child has been assigned. If the child has entered care but has not been committed, only a birth parent or judge can authorize treatment. The SSW will need to communicate with the judge or parent. Once the child is committed, the SSW may authorize treatment. If there is an “emergency” situation, the caregiver (foster parent) may authorize treatment if the SSW (child’s worker) or FSOS (supervisor) cannot be reached. LHDs may allow SSWs to sign consent for medical services prior to services being rendered, but no more than thirty (30) day prior to the service.

The bullets below are excerpts from the Cabinet for Health and Family Services, Department for Community-Based Services, Division of Permanency and Protection policy in regard to consents for medical services:

- *If the child is in the **emergency custody or temporary custody** of the Cabinet, only a parent or judge grants approval for medical procedures. A blanket consent by the court for medical services that are for prevention and treatment is sufficient. In an emergency when the child requires immediate medical attention and the parent or judge cannot be located, the social worker or supervisor authorize treatment. When the social worker or supervisor cannot be located, the **caregiver** authorizes treatment.*
 - *If the child is **committed**, the social worker or supervisor may authorize treatment. In an emergency, when a child needs immediate medical treatment and the social worker or supervisor cannot be notified, the **caregiver** authorizes treatment.*
 - *If a child is on a **voluntary commitment**, the social worker or supervisor consents to treatment when a parent cannot be located, in cases of serious illness or major surgery. In an emergency, when the child requires immediate medical attention and the social worker or supervisor cannot be located, the **caregiver** authorizes emergency medical treatment.*
6. For WIC certification services only, a minor patient seeking WIC as pregnant, a parent, caretaker, or proxy may provide current health data or birth measures, income and diet information and sign the general consent. A guardian or proxy may sign the general consent for WIC services (see “Use of Proxies” in the AR, Volume II, WIC Section).

CHILDREN (<18 years of age) NOT ACCOMPANIED BY A PARENT

The Kentucky Immunization Program recommends the following:

1. When an appointment is made for a child and the parent is unable to accompany the child, the follow should be followed:

The LHD should mail to the parent:

- Appropriate vaccine information materials
- The LHD consent form
- A statement which includes the LHD telephone number and information on how calls are taken

The parent should be encouraged to call for further information/questions. The LHD should encourage the parent to provide a phone number where they may be reached on the day the immunizations are to be given in case questions or concerns arise.

The **signed consent form** with the parent's emergency phone number **must** be returned to the LHD.

The parent should keep the vaccine information materials for future reference.

2. Informed consent may be obtained by telephone.

The LHD provider should place a telephone call to the parent, explain the proposed procedure thoroughly and provide **informed consent**. The LHD provider should explain the service to be performed, the risks, side effects, benefits, alternatives and comfort measures for the procedure. The parent should state understanding and give verbal consent. Another LHD employee should listen to the phone conversation to confirm the parent's oral consent. This information should all be documented in the medical record. The second LHD employee should document in the medical record to confirm the oral consent. The LHD should follow up with asking the parent to sign the consent form.

3. Persons or agencies having legal custody may provide consent.

Foster parents **cannot** sign for immunizations for children in their care. The appropriate signature should be obtained from the representative of the Commonwealth as designated by DCBS.

4. LHDs may choose to accept the consent of an adult non-parent having custody (other than legal custody) of a child if the LHD is satisfied there is **no risk** of being in conflict with parental decision-making. Reasonable efforts to obtain consent and needed medical information should be documented.
5. Another adult not having custody but accompanying the child can sign the consent if the parent has had access to vaccine information and the opportunity to get questions answered, and has **signed** delegation of authority to consent for the specific dose.

Note:

This policy will also apply to Tuberculosis skin testing, well-child services and other routine public health services. Exception to this policy is allowed for WIC services. Refer to the WIC Section, WIC Program Eligibility Requirements. Historically, Kentucky has a large number of children that are being reared by relatives that do not have legal guardianship, but are the primary caretakers of the child. These relatives should be encouraged to obtain a legal statement allowing them the ability to consent to medical care for these children. Efforts should be made to assist these families and children seeking service.

PROCEDURES FOR IMPLEMENTING THE RECORDS RETENTION AND DISPOSAL SCHEDULE FOR MEDICAL RECORDS

Retention Time Period For Medical Records

If the patient was less than 18 years of age on his/her last date of service, the record must be kept until he/she reaches age 18 plus 5 years, or 10 years whichever is the longer time period.*

If the patient was 18 years of age or older on his/her last date of service, the record must be kept for 10 years from the last date of service. *

- * For all patients (without regard to age), the immunizations (other than influenza), positive Purified Protein Derivative (PPD)s and any patient record with **documentation of Tuberculosis (TB) infection or disease treatment must be kept permanently.**

Note: If information on completed/ recommended treatment regimen, allergies, and sensitivities, regarding TB, is extracted and entered on the permanent immunization/master record, the record may be destroyed when it reaches the assigned retention period.

Master Patient Index

The Master Patient Index is the locator system for the medical records and is to be kept permanently. It shall be all-inclusive to contain the name and location of all active, inactive and destroyed patient records. When the record is removed from the active file, a notation on the index shall indicate where the record is and if the record is reactivated, a notation is to be made. If the record meets the retention period and is destroyed, a note is to be included to indicate the record was destroyed and the date of destruction.

Procedures For Archiving

Following are procedures to use in archiving medical records in accordance with the December, 2001 Records Retention Schedule:

The medical records retention schedule is based on three factors:

- (1) The last date of service; (2) patient's age (minor – less than 18 years of age and adult – 18 years of age and older); and (3) type of service the patient has received, i.e., Immunizations and positive tuberculosis (TB) test and TB infection or disease treatment.

The record retention criteria necessitate the date of birth being included on the label of the folder. (The C or D Label from the Patient Services Reporting System may be used).

- When the patient has not received a service within the past five years, the record is considered inactive and may be removed from the active files.
- In establishing the inactive files, consider the following:
 - (1) Minor patient records;
 - (2) Adult patient records; and
 - (3) Permanent records.

Location Of Inactive/Archived Records

Local health departments are responsible for the storage of inactive/archived records. The records must be stored in an orderly, accessible manner and in a secure location. The State Archives Center may not be used for storing local health department records.

Inactive/ Archived Records and/or Reports may be retained in electronic formats to provide a better source of storage to local health departments. The access should be easy, fast, and readily available when needed. The inactive/archived records and/or reports should be maintained according to the records retention schedule and properly disposed of once the retention period has ended.

Destruction Of Medical Records

If the medical record has met the required retention period, it should be destroyed. To destroy the record, it must be burned or shredded. A Records Destruction Certificate (Form PRD-50) is to be completed and mailed to the Department for Libraries and Archives, 300 Coffee Tree Road, Frankfort, Kentucky 40602. The PRD-50 forms may be obtained from the Department for Public Health Record Officer, Administration and Financial Management Division, phone number 502-564-7213. A copy of the Destruction Certificate is to be permanently maintained at the local health department.

PROCEDURES FOR RELEASE OF MEDICAL RECORD INFORMATION

Authorization To Release Information (Who May Sign)

The guidelines as to who may sign an authorization to release information are those applicable to the signing of consents for services. (See [Consent/Authorization for Services](#) in this section for guidance on obtaining consents. (For specific guidance on consents for Family Planning Services and Release of Family Planning information, see Family Planning Service Description in Section IX: Service Descriptions/Guidelines. The PHPR "Forms" folder includes the "Authorization To Release/Request Patient Information" Authorization To Release/Request Patient Information (CH-23).

Exceptions To The Use Of Written Release

In the event the local health department has a written agreement(s) with a hospital, private clinic, or primary care center, etc., to provide services which necessitate the sharing of medical information, a written release need not be completed provided the agreement states that confidentiality shall prevail and the patient (or legal representative) has been informed that the information will be exchanged only for the purpose of assuring "appropriate and continuous health care."

- Other exceptions include:
 - Research studies - Patient authorization is not required if identifying patient information is not released and/or included in research projects.
 - Third party payors - Specifically Medicare and Medicaid. (Permission to share is given when assignment of benefits is properly executed [signature, date, and name of agency providing the information]).
 - Sharing of childhood immunization information among providers.
 - Sharing WIC screens, certification and issuance information with other Kentucky WIC sites.

Other Considerations

- When releasing the medical record, entries related to STDs, Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome(AIDS), HANDS, alcohol and drug abuse, or psychological/mental problems shall be omitted from the record unless specifically authorized in the written release signed by the patient or guardian. Exception: Any STD on a child under 12 years of age shall be reported to the local health department or Social Services Office as a possible child abuse case.
- When confidential information is released over the telephone (e.g., to a physician, a hospital, or in a medical emergency), a reasonable attempt shall be made to verify the identity of the persons and/or facility receiving the information. Such information shall not be given to a patient or parent/legal guardian via telephone.
- When someone alleges they are the legal guardian or parent of a child and wishes to see the child's immunization record, the individual must complete a written request for information. The information shall be copied onto a personal immunization record and given to the individual. Other information such as the child's address and phone number shall not be released. It should be noted that a non-custodial parent may have a copy of his/her child's medical record provided that the non-custodial parent's parental rights have not been terminated.

- When medical records are viewed or photocopied for release and the record contains a report and/or correspondence from other agencies, these external reports become a part of the medical record of the receiving agency and may be released as such.
- The Release of Information form shall serve as the official request of patient information and shall be filed in the medical record (Administrative Section).
- Workmen's Compensation - Although consent for release of information is implied, the patient has the right to withhold consent in which instance the health department shall comply. (Workmen's Compensation proceedings will cease at this point.)
 - Certification(s) - Health departments may be requested to issue a "certification" of a specific service(s) they have provided (e.g., PPDs, to meet occupational requirements). Such certification shall be issued to the patient, who then has the responsibility to advise the employer. (No results of the service(s) shall be released to other than the patient without specific consent.) HIV test results are prohibited from use in employment or eligibility determination for health or life insurance.
- Upon a patient's written request, the LHD shall provide without charge to the patient, a copy of the patient's medical record. A copying fee, not to exceed one dollar (\$1) per page, may be charged by the LHD for furnishing a second copy of the patient's medical record upon request by the patient. For businesses, lawyers and others, the LHDs may charge a nominal and reasonable fee according to their agency's policy.

Coroner's Cases

A Coroner is a public official whose duty it is to make inquiry into the causes and circumstances of all sudden, unexplained, unnatural, or suspicious deaths.

The Coroner has authority, according to [KRS 72.020](#), to "take possession of any objects, medical specimens or articles which, in his opinion, may be helpful in establishing the cause of death, and he can make or cause to be made such tests and examination of said objects as may be necessary or useful in determining the cause of death." [KRS 72.415](#) gives coroners and deputy coroners the authority to "require the production of medical records" in carrying out their duties as peace officers in this state.

Additional Resource

For authorization and Coroner's exemptions refer to the [HIPAA](#) privacy regulations 164.908 and 164.512(c).

SAFEGUARDING OF SUBPOENAED RECORDS PRIOR TO COURT/DEPOSITION

A medical record subpoenaed for a legal case should be filed in a secure place until the case is terminated to prevent altering, tampering, or removing the record or any of its contents. Changes in the record occurring after the commencement of a lawsuit tends to display an admission of guilt. To provide the necessary security:

1. Number each page in the record.
2. Make a clear copy of the record.
3. File the original and the copy in a secure, locked place; and
4. Allow the original record to be viewed only under proper supervision.

To prevent anyone from making changes in the record after a suit has been filed, it is recommended that a second copy of the record be used for viewing by appropriate parties instead of the original/first copy that will be sent to court.

SUBPOENAS AND COURT ORDERS ([KRS 422.300 through KRS 422.330](#))

The Two (2) Types Of Subpoenas

1. Subpoena
The subpoena is a command to appear at a certain time and place to give testimony upon a certain matter.
 - A subpoena is valid if it:
 - a. Is issued by the court clerk or other authorized officer, but usually not the presiding officer of the court;
 - b. States the name of the court and the title of the action; and
 - c. Commands the person to whom it is directed to attend and give testimony at a time and place for a specified party.
2. Subpoena Duces Tecum
A subpoena duces tecum is a subpoena with the added command to bring along certain documents or papers pertinent to the issues of a controversy.

NOTE: For additional resources – Refer to [HIPAA](#) privacy regulations 164.512(e) and (f).

Court Order

A court order is a command signed by the presiding judge of the court.

Power To Issue

The power to subpoena is given by statute to judges, clerks of courts, referees, arbitrators, municipal corporations, legislative committees, various boards and commissioners including the State Board of Medical Licensure.

Responding To A Subpoena

Recipient is the person named in the subpoena to appear or produce documents or other materials.

A subpoena may be served by any person over eighteen (18) years of age by personally delivering a copy to the person to whom it is directed. **Mail Service is not appropriate.**

The service of a subpoena must be made to the person named in the subpoena. Service is valid when it is served within the territorial jurisdiction of the court that issued it.

- State - a subpoena issued by a state district or circuit court is valid only within the boundaries of the state in which the court is located.
- Federal - A subpoena issued by a federal court is valid within the federal court district or within one hundred (100) miles of the location where the witness is required to attend, even though the place of service may be outside of the federal court district.

Responsibility Of Recipient

The named recipient at the local health department should require proper service. When a subpoena is received through the mail, is sent from outside the court's jurisdiction, or is served improperly in any other way, the recipient should notify the attorney who initiated the subpoena of improper service. A form letter may be prepared to respond to such occasions.

Contempt Of Court

Failure to respond to a subpoena in Kentucky is punishable as contempt of court. Failure to compensate the witness for expenses is not sufficient grounds for failure to respond to a subpoena.

The Custodian Of Medical Records As Witness

When medical record information is subpoenaed, the custodian of medical records, i.e., either the medical record director or someone else with knowledge of the recipient's record maintenance procedures, will be asked to testify as to the authenticity of the medical records either through deposition, appearance at court or written certification.

Deposition

A deposition is the testimony of a party or witness, made under oath but not in open court and written down or videotaped to be used during discovery or trial proceedings.

The deposition is a means of pretrial discovery. It may direct the response to questions and/or production of records related to the case.

The attorney issuing the subpoena for a deposition to discover medical records usually will call the medical record custodian to set a time and place for the disposition. Those present at the deposition are the following:

1. Custodian of medical records.
2. Attorney requesting the deposition.
3. Opposing attorney, and
4. Court reporter or person with a video camera commissioned to record the deposition proceedings.

The medical record custodian will be sworn in and questioned in the same manner as if appearing in court. The attorney who issued the subpoena will be given the copy of the record when and if it is requested. If an attorney objects to the answering of a question during a deposition, the question is still answered. Whether or not an answer given during deposition will be introduced in court will be determined by the judge at a later time.

Appearance In Court

Prior to appearance in court, the medical record custodian should:

1. Make a clear copy of the record,
2. Number the pages on the copy, and
3. Read through the entire record for familiarity with the terms should it become necessary that portions have to be read in court at the deposition.

On the day appearance in court is requested, the medical record custodian should:

1. Call the attorney who subpoenaed the record and verify the time to be present, and

2. Bring the original and the copy of the record along to court.

Upon arrival at the court the medical record custodian should:

1. Acknowledge the custodian's presence to the subpoenaing attorney or the clerk of court.
2. Wait in the designated area until requested to take the witness stand and do not reveal the contents of the records to anyone until directed to do so by the judge.

The reasons a medical record custodian is asked to serve as a witness are to identify the record and answer questions needed to make the record admissible in court. Questions that must be answered positively for admissibility are:

1. Was the record made in the regular course of business; and
2. Was it the regular course of business to make such records at or near the time of the matter recorded?

When serving as a witness in court or at a deposition, the medical record custodian should answer questions briefly and directly. In addition to the two questions stated above, other usual questions are:

1. What is your full name and title?
2. For which facility do you work?
3. Do you have in your possession the medical records of _____?
_____?

In the event an attorney asks, "do you have ALL the records of _____?" the custodian must think of the filing system used and determine if ALL records were brought, including the HANDS record if filed separately. The medical record custodian may read parts of the record if asked, but may not interpret any medical information in the record. "I am not qualified to answer that," is a perfectly acceptable response when questions fall beyond the area of competence. All answers are subject to cross examination(s) in a court of law.

If any attorney objects to a question, the question should not be answered until the judge rules whether or not the question is to be answered.

Procedure For Mailing Records To Court

[KRS 422.300 through KRS 422.330](#) provide for the mailing or personal delivery of a certified copy of the medical record to the clerk of court, unless the record contains information regarding sexually transmitted diseases, HANDS, mental health or drug and alcohol abuse. In this event, the judge must be notified that privileged information on a specific patient is not subject to subpoena.

To comply with these statutes, the custodian of medical records or person charged with such responsibility shall promptly notify in writing the attorney causing service of the subpoena of the recipient's decision to submit a certified copy. Also included would be the cost of reproducing the record.

Upon payment of the copying expenses:

1. Prepare a certification with the following information:
 - a. Full name of the patient;
 - b. Patient's medical record number;
 - c. Number of pages in the medical record; and
 - d. This statement:

"The copies of records for which this certification is made are true and complete reproductions of the original (or microfilmed) records which are housed in (name of facility). The original records were made in the regular course of business, and it was the regular course of (name of facility) to make such records at or near the time of the matter recorded. This certification is given pursuant to KRS 422.300 – KRS 422.330 by the custodian of the records in lieu of personal appearance."
2. Notarize the certification;
3. Enclose the copies and notarized certification in an inner envelope labeled with the following:
 - a. Copies of medical records;
 - b. Title and number of the legal action or proceeding;
 - c. Date of the subpoena;
 - d. Name of the provider;
 - e. Full name of the patient;
 - f. Patient's medical record number, and
 - g. Name and business phone number of the employee signing the certification.
4. Seal the envelope and enclose the inner envelope containing the copies and certification into an outer envelope and address it to the attorney causing service of the subpoena or to the clerk of the court; and
5. Promptly deliver either personally or by certified or registered mail to the addressee. If delivered personally, have the person receiving the records sign a receipt containing the following information and retain the receipt as proof of the delivery:
 - a. Name of the facility;
 - b. Full name of the patient;
 - c. Patient's medical record number and;
 - d. The date the copies were delivered. When delivered via mail, retain the receipt issued by the post office and signed by the court representative as proof of delivery.

Original Record To Be Left In Court

If the original record is to be left in the court, the medical record custodian should obtain a receipt from the clerk of court indicating that the record will be retained in the clerk's custody and that arrangements will be made for the return of the record when the case is terminated.

Microfilmed Records In Court

If a subpoenaed record is on microfilm and it is necessary for the custodian to appear in court, the film containing the records should be taken to court with copies of the filmed records. If copies are legible, the filmed records ordinarily are not needed.

Should the court request the viewing of film that contains records of other patients, the custodian should explain that violation of the confidentiality of other patients' records is at stake. Such film should not be left with the court since the records may be needed for patient care.

Upon the admission of microfilm records in court, the medical record custodian may be asked if the original records were destroyed in the regular course of business. Records are destroyed "in the regular course of business" when they are destroyed in a routine manner after microfilming and not for the purpose of destroying evidence.

Interrogatories

Interrogatories are a set or series of written questions asked by one party of another party or witness in a lawsuit. The person receiving the interrogatory is requested to answer the questions in writing and to sign an oath that all answers are correct to the best of his/her knowledge. Answers are mainly used to discover evidence; however, the answers themselves may be admitted as evidence.

A recipient of a subpoena who is asked to answer an interrogatory or set of interrogatories should turn the questions over to his/her legal counsel for response.

Waiver of Privilege

A privilege may be waived only by the person whose information is held to be privileged. The recipient of the subpoena should never assume that a patient has waived privilege, for example, when a psychiatric patient sues his psychiatrist. Only the presiding officer of a court may determine that a patient has waived privilege.



RECORDS RETENTION SCHEDULE

LOCAL HEALTH DEPARTMENT



Prepared by
LOCAL RECORDS BRANCH
Public Records Division
Kentucky Department for Libraries and Archives

Printed with State Funds

Retention Time Periods Adopted by Type of Record

(See the Official Records Retention Schedule on the following pages.)

RECORD	1 yr.	2 yr.	5 yr.	6 yr.	10 yrs adults ⁵ <u>23 yrs minors*</u>	LHD-Discretion**
Patient Management Logs						
Mammogram Log	X					
Pap Log (manual log)	X					
Pap Log Report 323	X					
TB Skin Test Log and Positive PPD Log	X					
Laboratory Records						
Lab Request Forms and Lab Quap Audit Forms		X				
Lab Control Log		X				
Drug/Device Logs, Vaccine Records						
Drug Log and Oral Contraceptive Log			X			
Depo/Lunelle Log			X			
STD Med Log and TB Med Log			X			
Vaccine Log, Vaccine Return and Adj. Log			X			
Vaccine Shipping Invoice			X			
Financial Records						
Medicaid Managed Care, Medical/Dental, Claims Reports				X		
Patient Accounts Receivable (A/R) Reports and A/R Aging Reports				X		
Payment Authorization Log				X		
PEFs and Related Reports				X		
Patient Services Supplemental Reporting Forms & Reports				X		
UPS Shipping Books				X		
First Steps Report 819 (Billing Report)				X		
Influenza Vaccine Administration Record				X		
Home Health Records						
Home Health (HH) Admission/Discharge Reports				X		
HH Incident and Complaint Forms				X		
HH Oasis Logs				X		
HH Patient Invoice and HH Statistical Reports				X		
HH Recert Register				X		
HH Statistical Reports				X		
Patient Record						
Patient Medical Record (Complete Record or if patient received only Incidental services, e.g., PPD, Head Lice Check, etc.)					X	
HANDS Record (When not part of unit record)					X	
Patient Record for WIC Only (i.e., Fort Campbell)					X	
Patient Record for School clinic (bandages, aspirin, etc.)					X	
LHD Internal Management Records, etc.						
MHMR Referrals (Old records should be destroyed)						X
PKU Referrals (Non health department patients)						X
HH Referral Logs (Not needed beyond completion of annual report)						X
HH Aide Scheduling, Mail and Travel Logs						X
HH Staff Calendars with Patient Schedules						X
HIV Counseling/Testing Form						***
Commission for Children with Special Health Care Needs Records (Non health department patients)						****

NOTE: **Official Correspondence** has a permanent retention period and is defined as "Documents the major activities, functions, events and programs of an agency and in addition helps in the establishment of an administrative history. Provides a record of policy evolution and formulation, how and why decisions are made, and how these decisions impact the agency and public at large. Usually created by the chief administrative officer of the agency but may be supplemented by administrative heads of official departments, commissions, boards and agencies within the agency." (Local health department.)

⁵ For adults and minors, if the patient record contains documentation of TB infection or disease treatment, the information has a permanent retention period. See the "Records Retention Schedule" for explanation.

* Minors' records keep until age of majority (18 years) plus 5 years or 10 years whichever is longer.

** Destroy when obsolete or no longer useful to the LHD.

*** Optically scanned form – temporary record used until info is scanned.

**** Legal Counsel advised if patient has unit record, file in it, if not, send to the Commission.

Revised 07/30/02

RECORDS RETENTION SCHEDULE

Signature Page

LOCAL HEALTH DEPARTMENT

December 13, 2001

Agency

Schedule Date

Unit

Change Date

December 13, 2001

Date Approved by Commission

APPROVALS

The undersigned approve of the following Records Retention Schedule or Change:

Agency Head

Date of Approval

Agency Records Officer

Date of Approval

State Archivist and Records Administrator
Director, Public Records Division

Date of Approval

Chairman, State Archives and Records Commission

Date of Approval

The undersigned Public Records Division staff have examined the record items and recommend the disposition as shown:

Records Analyst/Regional Administrator

Date of Approval

Appraisal Archivist

Date of Approval

State/Local Records Branch Manager

Date of Approval

The determination as set forth meets with my approval.

Auditor of Public Accounts

Date of Approval

RECORDS RETENTION SCHEDULE

A-1

STATE ARCHIVES AND RECORDS COMMISSION
Public Records Division
Kentucky Department for Libraries and Archives

LOCAL HEALTH DEPARTMENT
Administrative

Schedule Date: December 13, 2001

Series No.	Record Title and Description	Retain at Agency (Years)	Disposition Instructions
L5207	Board of Health Minutes (C) Mtgs. open to public; Sub. to Ky. open mtg. laws (V)	P	Retain
L2116	Establishment of Public Health Tax Rate	P	Retain
L5208	Official Correspondence	P	Retain
L5209	General Correspondence	2	Destroy
L5210	Informational and Reference Material	I	Destroy when obsolete or no longer useful to the agency.
L5211	Official Budget	P	Retain
L5212	Final Closeout Reports (V)	P	Retain
L5213	Audit Report	P	Retain
L2123	Financial Records File	6	Destroy after audit
L5214	Individual Personnel Files (C) KRS 61.878	I	Destroy 70 years from date first employed
L5215	Certification of Eligibles	1	Destroy
L2128	Internal Management Reports Other than Financial (e.g., Patient Appointments, Staff Schedules, Monthly Patient/Client Statistical Computer Reports) (C) KRS 194A.060; KRS 61.878(1)(a)	I	Destroy when obsolete or no longer useful.
L5216	Inventory of Equipment	I	Destroy 3 years after update is completed and audit.
L2135	Vaccine Activity Worksheet & Order Record	1	Destroy

C = Confidential Record

I = Indefinite

P = Permanent

V = Vital Record

RECORDS RETENTION SCHEDULE

A-2

STATE ARCHIVES AND RECORDS COMMISSION
Public Records Division
Kentucky Department for Libraries and Archives

LOCAL HEALTH DEPARTMENT
Administrative

Schedule Date:

Series No.	Record Title and Description	Retain at Agency (Years)	Disposition Instructions
L5161	Reportable Disease Records (C) KRS 194A.060; KRS 61.878(1)(a)	I	If the individual has a medical record, file the report in the medical record. If the individual does not have a record, destroy when no longer useful to the local health department.
L5217	Open Records Request for Inspection/Disposition Record (This record series documents requests for information from the public, press, or other governing agency. It is a joint form that also documents approval and/or denial of information and supporting documentation). May include the date of request, requesting party name, information requested, copies needed or only viewing, disposition and supporting documentation for decision). (V)	1	Destroy

C = Confidential Record

I = Indefinite

P = Permanent

V = Vital Record

RECORDS RETENTION SCHEDULE

B-1

STATE ARCHIVES AND RECORDS COMMISSION
Public Records Division
Kentucky Department for Libraries and Archives

LOCAL HEALTH DEPARTMENT
Medical Information

Schedule Date: December 13, 2001

Series No.	Record Title and Description	Retain at Agency (Years)	Disposition Instructions
L2139	Master Patient Index (C) KRS 194.060; KRS 61.878(1)(a)	P	Retain
L2140	Adult Patient Medical Record (C) KRS 194A.060; KRS 214.420; KRS 61.878(1)(a)	I	Destroy 10 years after the last date of service. Exception - if the patient has had tuberculosis and the treatment regimen, allergies, sensitivities and reactions have not been extracted and documented on the Immunization/Mastercard, the record must be kept permanently.
L5157	Minor Patient Medical Record (C) KRS 194A.060; KRS 214.420; KRS 61.878(1)(a)	I	Destroy 5 years after the patient reaches 18 years of age or 10 years from last date of service whichever is longer. Exception - if the patient has had tuberculosis, and the treatment regimen, allergies, sensitivities and reactions have not been extracted and documented on the Immunization/Mastercard, the record must be kept permanently.
L2144	Pap Smear, Mammogram and Abnormal CBE Logs (C) KRS 194A.060; KRS 214.420; KRS 61.878(1)(a)	I	Destroy 1 year from followup service date.
L2145	Patient Drug and Device Log (C) KRS 194A.060; KRS 61.878(1)(a)	5	Destroy
L2146	Tuberculosis Chest X-Rays (C) KRS 194A.060; KRS 61.878(1)(a)	P	Retain
L5159	Immunization Record (Master Record) (C) KRS 194A.060; KRS 61.878(1)(a)	P	Retain

C = Confidential Record

I = Indefinite

P = Permanent

V = Vital Record

RECORDS RETENTION SCHEDULE

B-2

STATE ARCHIVES AND RECORDS COMMISSION
Public Records Division
Kentucky Department for Libraries and Archives

LOCAL HEALTH DEPARTMENT
Medical Information

Schedule Date:

Series No.	Record Title and Description	Retain at Agency (Years)	Disposition Instructions
L5160	Perinatal Hepatitis B Prevention Form for Infants (C) KRS 214.420; KRS 194A.060	1	File the form in the infant/child's chart if a chart is created. If the infant/child never becomes a patient of the LHD destroy in 2 years.
L5164	Incident/Accident/Complaint Reports (C) KRS 61.878(1)(a)	1	Destroy 5 years after accident/incident occurred for adults. For children keep until age 18 years plus 5 years or until litigation is complete whichever time period is longer.
L5162	Laboratory Records for CLIA (C) KRS 214.420; KRS 194A.060	2	Destroy
L5163	HIV/AIDS Care Coordinator Client Record (C) KRS 214.420; KRS 61.878(1)(a); KRS 194A.060	3	Destroy

C = Confidential Record

I = Indefinite

P = Permanent

V = Vital Record

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RECORDS RETENTION SCHEDULE

C-1

STATE ARCHIVES AND RECORDS COMMISSION
Public Records Division
Kentucky Department for Libraries and Archives

LOCAL HEALTH DEPARTMENT
Vital Statistics

Schedule Date: December 13, 2001

Series No.	Record Title and Description	Retain at Agency (Years)	Disposition Instructions
L2153	Certificate of Live Births (V)	P	Retain
L2154	Certificate of Stillbirth (V)	P	Retain
L2155	Death Index-Report 677 (V)	P	Retain
L2156	Birth Index by Name of Child (V)	P	Retain
L2157	Birth Index by Maiden Name of Mother (V)	P	Retain
L2158	Permit for Disinterment and Reinterment in the Same Cemetery (V)	P	Retain
L2159	Application for Permit to Disinter and Reinter in Same Cemetery (V)	P	Retain
L2162	Provisional Certificate of Death (V)	I	Destroy when death appears on Death Index Report 677

C = Confidential Record

I = Indefinite

P = Permanent

V = Vital Record

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RECORDS RETENTION SCHEDULE

D-1

STATE ARCHIVES AND RECORDS COMMISSION
Public Records Division
Kentucky Department for Libraries and Archives

LOCAL HEALTH DEPARTMENT
Rabies Control

Schedule Date: December 13, 2001

Series No.	Record Title and Description	Retain at Agency (Years)	Disposition Instructions
L2163	Rabies Vaccination Certificate	5	Destroy
L2164	Animal Quarantine Notice	1	Destroy
L2165	Notice and Order to Vaccinate Dog Against Rabies	1	Destroy

C - Confidential Record

I - Indefinite

P - Permanent

V - Vital Record

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RECORDS RETENTION SCHEDULE

E-1

STATE ARCHIVES AND RECORDS COMMISSION
Public Records Division
Kentucky Department for Libraries and Archives

LOCAL HEALTH DEPARTMENT
Home Health

Schedule Date: December 13, 2001

Series No.	Record Title and Description	Retain at Agency (Years)	Disposition Instructions
L5218	Home Health Advisory Committee Minutes	P	Retain
L2142	Adult Patient Home Health Medical Record (C) KRS 194A.060; KRS 214.420; KRS 61.878(1)(a)	I	Destroy 6 years after last date of service.
L5158	Minor Patient Home Health Medical Record (C) KRS 194A.060; KRS 214.420; KRS 61.878(1)(a)	I	Destroy 5 years after the patient reaches 18 years of age or 6 years from last date of service whichever is greater.

C = Confidential Record

I = Indefinite

P = Permanent

V = Vital Record

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RECORDS RETENTION SCHEDULE

F-1

STATE ARCHIVES AND RECORDS COMMISSION
Public Records Division
Kentucky Department for Libraries and Archives

LOCAL HEALTH DEPARTMENT
Women, Infant, and Children

Schedule Date: December 13, 2001

Series No.	Record Title and Description	Retain at Agency (Years)	Disposition Instructions
L2171	WIC Revalidation Information	3	Destroy -pending written notification of resolution of state/federal audit.
L2174	WIC Vendor File	3	Destroy after written notification of resolution of State/Federal audit.

C = Confidential Record

I = Indefinite

P = Permanent

V = Vital Record

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RECORDS RETENTION SCHEDULE

G-1

STATE ARCHIVES AND RECORDS COMMISSION
Public Records Division
Kentucky Department for Libraries and Archives

LOCAL HEALTH DEPARTMENT
Food and Sanitation

Schedule Date: December 13, 2001

Series No.	Record Title and Description	Retain at Agency (Years)	Disposition Instructions
L2175	Establishment Files (Businesses which have obtained operating permits) (Some records are exempted by the Open Records Law KRS 61.878.) (C)	1	Destroy 2 years after last date of activity.
L2176	Onsite Sewage Files	P	Retain
L2177	Applications for Permit to Operate (Access Restrictions: Any records contained in file which are exempted under Open Records Law. KRS 61.878.) (C)	2	Destroy after audit
L2181	Environmental Health Management Information System Reports	5	Destroy after audit
L2182	Plats, Maps, Surveys, Blueprints and Plan Review Sheets -- (other than onsite)	3	Destroy

C = Confidential Record

I = Indefinite

P = Permanent

V = Vital Record

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